



Children's Mental Health

Child/Adolescent Diagnostic Assessment

(TO BE COMPLETED BY PARENT/CAREGIVER)

PART 1 – Please provide the following information in preparation your interview with your mental health clinician.

DATE

CHILD NAME (FIRST, MI, LAST)	CLIENT NUMBER	REFERRAL SOURCE
REASON FOR REFERRAL		

Living situation

Parent's Home <input type="checkbox"/> RENT <input type="checkbox"/> OWN	Residential Care/Treatment Facility** <input type="checkbox"/> HOSPITAL <input type="checkbox"/> TEMPORARY HOUSING <input type="checkbox"/> RESIDENTIAL CARE <input type="checkbox"/> NURSING HOME	Other** <input type="checkbox"/> FRIEND'S HOME <input type="checkbox"/> RELATIVE/GUARDIAN'S HOME <input type="checkbox"/> HOMELESS
---	---	---

**IDENTIFY PERSON'S NAME OR FACILITY

Primary Household

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

STREET ADDRESS (If different from child's address listed on Demographic Information form.)

Does the client live in more than one household?

NO If no, skip to "Additional Family Members" **YES** If yes, complete the secondary household information below.

Secondary Household

Household member name	Relationship to child	Age	Occupation/School	Highest level of education	Quality of relationship

STREET ADDRESS (If different from child's address listed on Demographic Information form.)

Family members who live in both households

ONLY CHILD

CHILD and (list): _____

Additional family members

NO, parents or sibling other than those listed in primary or secondary households

YES, list family members: _____

Custody and parenting plan

LIVES WITH BOTH PARENTS (biological or adoptive) in same household

SINGLE PARENT

SHARED CUSTODY – parents in different households

OTHER (describe): _____

Developmental issues

Have you ever had concerns about the following issues with this child?

Pregnancy	Yes	No	Unknown
Had bleeding during first three (3) months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had bleeding during second three (3) months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had bleeding during last three (3) months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had toxemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had to take medications Specify any medication: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Got injured or hurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gained less than 15 lbs. (7 kgs.) Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Took narcotic drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drank alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had an infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoked during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length of pregnancy: _____ months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other pregnancy problems/illnesses Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birth/Early Infancy	Yes	No	Unknown
Born prematurely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Born with cord around neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injured during birth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turned blue (cyanosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was a twin or triplet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had an infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had seizures (fits, convulsions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Needed oxygen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was very jittery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Childhood Health Issues	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Seizures (convulsions) or spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
High fevers (over 103° F. or 39° C.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Trouble with hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Trouble with vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Lead poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other poisoning or overdose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other serious illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Functioning	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Trouble staying asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Overactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Head banging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Rocking in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Self-destructive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Difficulty in being comforted or consoled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Stiffness or rigidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Looseness or floppiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Crying often and easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Shyness with strangers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Extreme reaction to noise or sudden movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Attention problems	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Can concentrate for only a short time unless things are very interesting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Understand the main ideas of things but misses important details	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Does work or performs many tasks carelessly without thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Learns a new skill well one day and then can't seem to do it a few days later	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Receives very unpredictable (inconsistent) grades or test scores in school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Can work well only on things he/she really enjoys doing or thinking about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

Often doesn't notice when he/she makes mistakes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Seems not to realize when he/she is disturbing someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Doesn't do much better after punishment or correction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Makes comments about or is distracted by background noises or unimportant things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Seems to want things right away and/or is hard to satisfy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Annoys or bothers other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Behavior is variable and hard to predict	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is a troublemaker; bullies others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Behaviors	Yes	No	Unknown	If yes, age first noted	If yes, still occurring?
Has bad dreams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often very quiet or withdrawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often "down" on himself/herself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Speaks unclearly, stutters, or stammers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Wets bed or pants often	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Soils underwear or has accidents with bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often too neat or orderly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is often too concerned about cleanliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Often plays with matches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Destroys objects at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Destroys objects away from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is fearless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is cruel to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is not liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Feels ill on school mornings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Has eating problems (either overeats or undereats)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is preoccupied with food or diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Is part of a clique or gang that causes trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other behaviors not noted above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Have you ever had concerns about your child's early development (i.e. walking, talking, learning)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Have you ever had concerns about your child's sexual development or behaviors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

IF THERE ARE INDICATIONS OF ISSUES, PLEASE EXPLAIN

Child's school functioning

Education classification	
Does your child have an IEP for special education services? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If no, has your child ever been tested and determined not to need services? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Regular education classroom, no special services <input type="checkbox"/> YES <input type="checkbox"/> NO	
If no, check all that apply below.	
<input type="checkbox"/> Early Childhood Spec. Ed./Developmental Delay	<input type="checkbox"/> Special learning disability
<input type="checkbox"/> Special Learning Disability	<input type="checkbox"/> Autism Spectrum Disorder
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Other health impaired
<input type="checkbox"/> Speech or Language Impaired	<input type="checkbox"/> Unsure
<input type="checkbox"/> Physically Impaired	<input type="checkbox"/> Current 504 plan
<input type="checkbox"/> Emotional/Behavioral Disorder	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Developmental/Cognitive Disability	_____
COMMENTS ON EDUCATIONAL CLASSIFICATION	

Child's legal history

Does your child have a history of legal charges? <input type="checkbox"/> NO <input type="checkbox"/> YES	
IF YES, DESCRIBE CHARGES	

Is the child currently on probation? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Has the child ever been on probation? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Has the child ever been court-ordered into chemical health or mental health treatment? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Has the child ever had involvement with Child Protective Services (CPS)? <input type="checkbox"/> NO <input type="checkbox"/> YES	
IF YES, DESCRIBE	

NAME OF CPS CASEWORKER(S) ASSIGNED TO FAMILY (IF APPLICABLE)	
	<input type="checkbox"/> NONE REPORTED
NAME OF GUARDIAN AD LITEM (GAL) OR COURT APPOINTED SPECIAL ADVOCATE (CASA) ASSIGNED TO FAMILY	
	<input type="checkbox"/> NONE REPORTED

Child's trauma history

Has your child experienced or witnessed any of the following? (check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Other accident | <input type="checkbox"/> Physical illness | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Domestic violence/abuse | <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Physical neglect | <input type="checkbox"/> Sexual assault/molestation |
| <input type="checkbox"/> Community violence | <input type="checkbox"/> Fire | <input type="checkbox"/> Natural disasters | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> None of the above | | | |

Child's mental health treatment history

Previous mental health treatment NO YES If yes, please list reason for treatment, and dates:

Reason	Dates

Currently on any medication(s)? NO YES

IF YES, PLEASE LIST AND BRING MEDICATIONS TO NEXT APPOINTMENT

PRIMARY CARE PHYSICIAN			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE
OTHER PRESCRIBING PHYSICIAN(S)			PHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE

Child's alcohol and drug history

Do you have any concerns about your child's use of alcohol or drugs? NO YES

Do you have any other issues or concerns about your child you would like to have addressed? NO YES

COMMENTS

Family Environment/Relationships

Please indicate below the best descriptions of parent-child relationships.

Parent-Child (Client) Relationship(s)	P = Primary household		S = Secondary household		B = Both
Parent-child conflict	<input type="checkbox"/> NONE – MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE		
Issues with supervision and monitoring of child	<input type="checkbox"/> ALWAYS	<input type="checkbox"/> USUALLY	<input type="checkbox"/> INCONSISTENTLY	<input type="checkbox"/> RARELY	
Cooperation between parents regarding child-rearing	<input type="checkbox"/> ALWAYS	<input type="checkbox"/> USUALLY	<input type="checkbox"/> INCONSISTENTLY	<input type="checkbox"/> RARELY	<input type="checkbox"/> NOT PERTINENT
Parent positive activities with child	<input type="checkbox"/> FREQUENT	<input type="checkbox"/> OCCASIONALLY	<input type="checkbox"/> INFREQUENT		
Parent satisfaction with relationship	<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED		
Child satisfaction with relationship	<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED		
COMMENT ON PARENT-CHILD RELATIONSHIPS (describe further if needed)					

Please indicate below the best descriptions of sibling-child relationships.

Sibling-Child (Client) Relationship(s)	<input type="checkbox"/> NO SIBLINGS	P = Primary household	S = Secondary household	B = Both
Child-sibling conflict		<input type="checkbox"/> NONE – MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Sibling(s) positive activities with child		<input type="checkbox"/> FREQUENT	<input type="checkbox"/> OCCASIONAL	<input type="checkbox"/> INFREQUENT
Sibling(s) satisfaction with relationship		<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED
Child satisfaction with relationship		<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED
COMMENT ON SIBLING-CHILD RELATIONSHIPS (describe further if needed)				

Please indicate below the best descriptions of parent marital or couple relationships.

Parent Marital or Couple Relationship(s)	<input type="checkbox"/> NOT APPLICABLE	P = Primary household	S = Secondary household	B = Both
Marital or couples conflict		<input type="checkbox"/> NONE – MILD	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE
Marital or couples satisfaction		<input type="checkbox"/> SATISFIED	<input type="checkbox"/> NEUTRAL	<input type="checkbox"/> DISSATISFIED
COMMENT ON PARENT MARITAL OR COUPLES RELATIONSHIPS (describe further if needed)				

